3. EXCESS REVENUE X 0.35 = AMOUNT OF REVENUE RETAINED BY HOSPITAL (AND ADDED TO BASE)

4. EXCESS REVENUE X 0.65 = AMOUNT OF REVENUE REFUNDED TO THIRD PARTIES

CASE B: IF HOSPITALS ACTUAL INPATIENT ANCILLARY REVENUE IS LESS THAN BUDGETED INPATIENT ANCILLARY REVENUE, THEN:

1. BUDGETED REVENUE MINUS ACTUAL REVENUE EQUALS DEFICIT REVENUE

2. DEFICIT X 0.65 = AMOUNT PAID TO HOSPITAL ONLY IF:

   A. ACTUAL ADMISSIONS HAD DECREASED LESS THAN 10% OF BUDGETED ADMISSIONS, AND IF

   B. ACTUAL L.O.S. DID NOT EXCEED BUDGETED L.O.S. OR NATIONAL AVERAGE L.O.S.

   C. IF ADMISSIONS HAD DECREASED BY MORE THAN 10% OF BUDGET THEN THE SETTLEMENT BECOMES NEGOTIABLE.

3. OUTPATIENT VOLUME ADJUSTMENT

Increased utilization of outpatient care modalities as a direct substitute for inpatient care is a major incentive in the program. The following adjustment (subject to application of the outpatient R.C.C.) is designed to insure this incentive to hospitals and provides for each party to assume some risks for outpatient volume (hospitals for a decrease in volume; Third Parties for an increase in volume).

A. ACTUAL OUTPATIENT REVENUE MINUS BUDGETED OUTPATIENT REVENUE EQUALS EXCESS REVENUE

B. EXCESS REVENUE X 0.60 = AMOUNT RETAINED BY HOSPITAL (AND ADDED TO BASE)

C. EXCESS REVENUE X 0.40 = AMOUNT REFUNDED TO THIRD PARTIES

No adjustment will be made to the expense base when actual outpatient revenue is below budget revenue.

It should be noted that the Professional Component for direct patient care is not included in the outpatient adjustments.

Exhibit C contains examples of the application of the above adjustments.

The volume corridor adjustments payback will be calculated in the following manner.

1. Inpatient - Payback will be based on the relationship of each third party's program days to total days for the same fiscal period.
2. Outpatient - Payback will be based on the relationship of each third party's billed charges to total billed charges for the same fiscal period

Exhibit D contains example calculations.

This agreement applies to all three years of the experiment.

N. Patient Mix Adjustment

Where a hospital can demonstrate that a change in patient mix has occurred, it will be entitled to reimbursement to cover the expense associated with the change in patient mix. A hospital may request consideration of a patient mix adjustment based on the following: 1) The COLC Phase IV patient mix formula which uses actual to actual comparisons (form CLC 61 with appropriate schedules) shall be used to identify a potential patient mix problem. 2) However, a comparison of budget to actual data expenses, and revenues will be used to validate the occurrence of a change in patient mix and the impact on hospital expenses. 3) The final dollar adjustment will be negotiated. 4) There will be no application of this adjustment if the change in patient mix is to a mix of patients requiring a reduced level of intensity of care.

O. Incentives

Under this contract, the hospital assumes full responsiblity for all resulting losses and will retain full 100% benefit of all resulting gains.

The use of gains will be subject to the dollar limitation of the program planning process outlined in Exhibit A, as well as any other legislated planning process.

A gain cannot be used for implementation of: 1) a medical program subject to the dollar limitations of the planning process, but which has never been submitted, or 2) a program which has received a priority III in the program planning process, or 3) effective October 1, 1976 and thereafter, a program which has received a priority II, unless said pro-

gram is resubmitted through the planning process and reclassified as a priority I. Moreover, proposed expenditures realized from gains which may not be subject to review by the appropriate planning agencies, yet lead to an increase in ongoing expenses, would be subject to the same scrutiny and process of negotiations in the following year as any other proposed expenditure.

P. Major Contingency Clause

A major contingency may be requested by 1) an individual hospital, 2) a group of hospitals, or 3) the Third Parties. All major contingencies will be financed through any available reserves left in the MAXICAP after hospital budget negotiations are completed, and any settlements associated with volume corridor adjustments are concluded. However, it is possible that the reserve funds may prove inadequate. In such cases, adjustment of the MAXICAP would take place, provided the conditions outlined under "Major Contingency" are satisfied. Disputes as to whether or not a major contingency has in fact occurred will be resolved through the mediation and arbitration process outlined in Section V.

A Major Contingency shall be defined as an event(s) that is notable and conspicuous and unforeseen and unpredictable by the party who is adversely affected. A major contingency request may include an item or group of items. However, the group of items must all be related to a single notable and conspicuous, unforeseen and unpredictable event; but, each time in and of itself need not be notable and conspicuous. Also, each item within the group of items must qualify under the other criteria of this definition.

In determining whether an event is unpredictable and unforeseen, the parties may refer to the components of the MAXICAP or individual hospital budget negotiations. Although the parties may look at individual components in the negotiations, such components shall only be used as a frame of reference and neither party shall be bound precisely to what was negotiated/not negotiated.

It is not the intent of this provision to permit either party to introduce item(s) for inclusion which should have been unforeseen through prudent preparation and negotiation of budgetary data.

In filing for a major contingency, a hospital/group of hospitals must demonstrate that attempts were made to minimize the impact of an event through the use of prudent purchasing and management. Also, the hospital/group of hospitals must provide timely and accurate data on why the item(s) qualify as a major contingency and budget/actual revenue and expense data.

The actual dollar adjustment will be negotiable, and any granting of a major contingency shall not be related to a hospital's financial condition.

This process shall be completed within 60 days of the original filing.

Q. Renegotiation or Adjustment of the MAXICAP

Should the MAXICAP reserve be exceeded and as a result the negotiated MAXICAP be exceeded due to volume corridor adjustments and major contingencies as prescribed in Sections II - M, N, and P, any of the parties may request a renegotiation or adjustment of the MAXICAP.

4.19.A

Once renegotiation of the MAXICAP has been requested, the parties will follow the process as outlined in Section II-C entitled "State CAP Committee."

19.16

R. Amendment Period

This amendment extends the program beyond the period ending September 30, 1979.

S. Cash Flow Adjustment

To avoid a major cash settlement caused by any of the provisions outlined in this program, an interim adjustment can be made prior to year-end reconciliation subject to negotiations as to what the specific adjustment should be (upward or downward).

T. Policy Administration

A Policy Administration Committee composed of representatives from Blue Cross of Rhode Island, the State Budget Office, and the Hospital Association of Rhode Island will be established for the purpose of overseeing and interpreting the provision of this Prospective Rating Experiment.

U. Federal Cost Control Program

The parties are in agreement that should federal legislation be passed that would have the effect of imposing cost controls on hospitals, the parties will meet to assess the impact of such controls, and to mutually decide whether continuation of this contract is feasible.

V. Mediation and Arbitration

1. To assure equity and provide a method for resolving the MAXICAP and MAXICAP related issues, the following appeals process has been established:

R-1 ... 7/12/79 Incor. 7/23/79 ... 10-1-79

a. Negotiations and Mediation

Parties will negotiate until one party or both parties call for breaking off of negotiations and mediation is requested.

The two last best offers of the parties will be submitted, in writing, at a negotiating session.

- Bottom-line on the MAXICAP percentage.
- Respective positions on other MAXICAP issues.

  Examples of such issues are 1) interpretation of the volume corridors, 2) the expense base determining the dollars in the MAXICAP, 3) inclusion of malpractice or Professional Standard Review Organization expenses under the MAXICAP ceiling.

If the negotiators cannot resolve the difference in the last best offers at the session in which they are exchanged, the last best offers as presented will be referred to mediation.

The mediation panel will have one meeting only to resolve the difference in the positions.

Mediators have the option of choosing either position or developing a third or compromise position.

Mediation will not be binding. Either the Third Parties collectively may comply with the mediators' decision or disagree and opt for arbitration.

b. Mediation Ground Rules

The mediation panel shall consist of one hospital administrator, one member of the HARI executive structure, four hospital trustees (non

employee), three members of the Blue Cross Board, one member of the Blue Cross executive staff and two high level State officials appointed by the Governor. No member of the mediation panel may have participated in the negotiating process.

Participation of negotiators as presentors will be at the discretion of the mediation panel.

The mediation panel cannot refer the issues(s) back to negotiations.

2. To assure equity and provide a method for resolving issues, particularly individual hospital budgets but excluding the MAXICAP and MAXICAP related issues, the following appeals process has been established:

a. Negotiation and Mediation

Parties will negotiate until one party or both parties call for breaking off of negotiations and ask for mediation.

The last two best offers of the parties will be submitted, in writing, at the last negotiating session.

- Bottom-line on the hospital's budget expressed in dollars.
- Respective positions on other related issues, including the base.

If the negotiators cannot resolve the difference in the last best offers at the session in which they are exchanged, the last best offers as presented will be referred to mediation.

The mediation panel will have one meeting only to resolve the difference in the positions.

Mediators have the option of choosing either position or developing a third or compromise position.

Mediation will not be binding. Either the Third Parties collectively or the hospital may comply with the mediators' decision or disagree and opt for arbitration.

b. Mediation Ground Rules

The mediation panel for each hospital shall consist of six representatives appointed by H.A.R.I. (consisting of not more than three Trustee members from the affected hospital and three other members from within the boundaries of the State of Rhode Island), four from Blue Cross, and two high level State officials appointed by the Governor. No member of the mediation panel may have participated in the negotiating process of the hospital being mediated.

Each party shall have the opportunity to make one presentation to the mediation panel. Additional presentations and participation shall be at the mediation panel's discretion.

The mediation panel cannot refer the issue(s) back to negotiations.

The mediation process for an individual hospital will begin no later than 60 days from the date of that hospital's initial budget submission, and will be concluded within 75 days of budget submission.

3. Arbitration

For both mediation processes, if the mediators are unable to agree on a compromise position, or there is a disagreement between the third parties collectively or the hospitals collectively for the MAXICAP or the individual hospital for its budget on the mediators' compromise

position, then no position of the mediators will be submitted to arbitration.

The arbitrators must choose one of the last best written offers submitted to mediation.

The parties agree to use the American Arbitration Association (AAA) for all appeals. Using lists provided by the AAA, the State and Blue Cross will jointly select one member, the hospitals a second member and these two members will jointly select a third member. The decision of the arbitrators shall be binding on all parties, and the award shall be enforceable by appropriate legal proceedings.

If during the mediation/arbitration process an issue in question cannot be clearly dealt with given the contractual agreements as expressed in this document, Section IV of the revised Protocol describing this program will serve as the official reference for final interpretation.